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Dear Colleague:

The enclosed item lists resources produced by the Center for Health Promotion and Education or by its contractors. We are distributing this to assist you in locating resources related to your various health education projects and initiatives. Sources for these items are identified. To facilitate your access to these resources, we wish to bring your attention to the fact that many of these items are available from the National Technical Information Center, U.S. Department of Commerce, 5285 Port Royal Road, Springfield, VA 22161. These items are indicated by an asterisk in the enclosed resource list.

Sincerely yours,

Horace G. Ogden
Director
Center for Health Promotion
and Education

Enclosure

HE 20.7019:

HEALTH EDUCATION RESOURCES 1974-1980

JULY 1982

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INTRODUCTION

"CHPE Health Education Resources 1974-1980" contains abstracts of publications emanating from the former Bureau of Health Education, which in October 1980 became a primary component of the Center for Health Promotion and Education (CHPE). Included are publications which were written directly by CHPE or which resulted from projects, contracts, and cooperative agreements with other organizations.

A number of other organizational changes are reflected in the entries of this bibliography. The Center for Disease Control was reorganized as the Centers for Disease Control in October 1980, and the Department of Health, Education, and Welfare became the Department of Health and Human Services in May 1980.

To facilitate acquisition of items, the publication source line for each bibliographic entry reflects the current organizational name; however, both the corporate author and the content of the abstract reflect the organizational name at the time the publication was produced. In some instances, an organization other than CHPE is the principal source for the publication and is so indicated.

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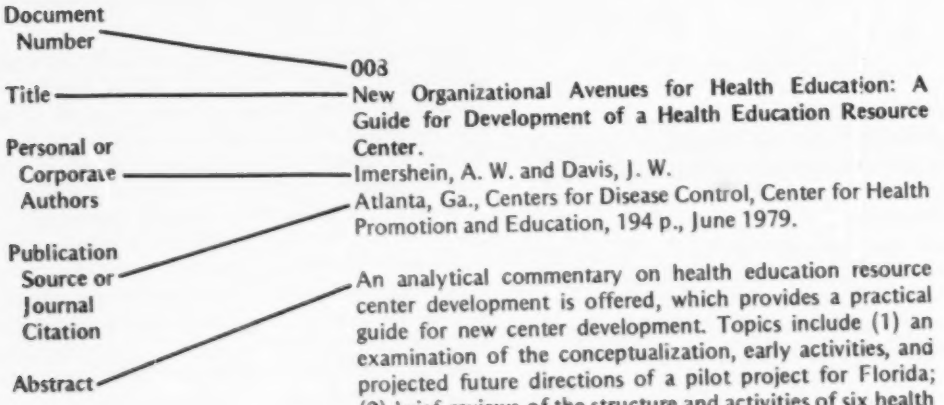
HOW TO USE THE BIBLIOGRAPHY

"CHPE Health Education Resources 1974-1980" is divided into 4 subject areas: Community Health Education, Patient Education, School Health Education, and Other. Each section consists of abstracts of reports, reprints, conference presentations, and research papers which were written directly by CHPE or which resulted from projects, contracts, and cooperative agreements with other organizations. These are listed alphabetically by author within each section, and a sequential number has been assigned to each item.

Each abstract is organized as depicted in the sample below:


Document Number
003
Title
New Organizational Avenues for Health Education: A Guide for Development of a Health Education Resource Center.
Personal or Corporate Authors
Imershein, A. W. and Davis, J. W.
Publication Source or Journal Citation
Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 194 p., June 1979.
Abstract
An analytical commentary on health education resource center development is offered, which provides a practical guide for new center development. Topics include (1) an examination of the conceptualization, early activities, and projected future directions of a pilot project for Florida; (2) brief reviews of the structure and activities of six health education resource centers in the United States; (3) the role, current activities, and future plans of health systems agencies in Florida; and (4) rules and guidelines for center development, focusing on organizational structure, bylaws, governing boards, staff, supplies, and budget. Several appendices include model drafts for elements cited in the above guidelines, the Senate Bill 552, a sample indexing system, a list of issues to be considered (when developing a resource center), and sample personnel policies.

The distributor from which an included item is available to the public is given if the publication source does not distribute the publication. Price information may be obtained from the supplier at the address given by specifying the order or stock number of the document and the form, hard copy of microfiche, desired. ITEMS WITH AN ASTERISK(*) PRECEDING THE DOCUMENT NUMBER ARE NOW AVAILABLE FROM THE NATIONAL TECHNICAL INFORMATION SERVICE, U.S. DEPARTMENT OF COMMERCE, 5285 PORT ROYAL ROAD, SPRINGFIELD, VA 22161.

"CHPE Health Education Resources 1974-1980" contains two indexes. They are (1) Author, which contains the names of personal and corporate authors of publications, and (2) Subject, which contains subject descriptors, including geographic location. Listed under each index item is the unique number assigned to the pertinent abstract.

COMMUNITY HEALTH EDUCATION

*001

Health Education and the Black Community (Report of a Meeting Held July 26-27, 1979, at the Bureau of Health Education, Center for Disease Control, Atlanta, Georgia 30333).

Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 82 p., December 1980.

A conference on "Health Education and the Black Community" was held at the Bureau of Health Education. During the conference, position papers were offered on the relevance of health education theories and their application to the black community, the impact of health education on black communities without changes in the external environment, the role of the health education process in improving the health status and quality of life in the black community, methodological and substantive issues in health education programming, school health education in black communities, health promotion among black populations, perspectives on health education and health promotion in the "black belt," competencies needed by health education personnel engaged in service to black communities, a categorical approach to comprehensive health promotion and disease prevention aimed at management of hypertension, prerequisites for health education in the black community, and health career development. Appendices include a participant roster, a list of issues that participants considered to need attention, and the agenda of the conference.

*002

American Hospital Association-Bureau of Health Education Health Education Project-Reimbursement Forum Proceedings, October 25, 1979, American Hospital Association.

American Hospital Association, Chicago, Ill. Center for Health Promotion.
Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 123 p., April 1980.

One of the major findings that emerged from contractual activities between the Bureau of Health Education and the American Hospital Association is that a lack of financial expertise on the part of professionals concerned with health education is a barrier to implementing health education programs in hospitals. This impediment extends from lack of technical skill in appropriate budgeting techniques to philosophical disagreements among interest groups involved in health education over the entire structure of third-party financial mechanisms and financial incentives in the health care industry. Previous work had also identified that practitioners in the field of patient education lack knowledge about which health education activities are currently reimbursable. A portion of contract activities was therefore designed to address the topics of budgeting, reimbursement, and financing. The reimbursement forum documented by these proceedings was designed to address these identified needs in a public exchange of views.

003

Model Standards for Community Preventive Health Services: A Report to the U.S. Congress From the Secretary of Health, Education, and Welfare.

American Public Health Association, Washington, D.C.; Association of State and Territorial Health Officials, Washington, D.C.; National Association of County Health Officials, Washington, D.C.; United States Conference of City Health Officers, Washington, D.C.; and Center for Disease Control (DHEW, PHS), Atlanta, Ga.
Washington, D.C., Office of the Assistant Secretary for Health and Surgeon General, DHEW, 110 p., August 1979.

Model standards covering 28 program areas related to community preventive services are presented. In addition to preventive service delivery, the standards address some of the regulatory aspects of prevention, such as environmental health. Program areas covered include administrative and support services, air quality, chronic disease control, communicable disease control, dental health, emergency medical services, family planning, food protection, genetic disease control, health education, home health services, housing services, injury control, institutional services, maternal and child health, noise control, nutritional services, occupational health, primary care, public health laboratories, radiological health, safe drinking water, sanitation, school health, solid waste management, surveillance and epidemiology, vector and animal control, and wastewater management.

*004

Health Education in the Cooperative Extension Service: Present Status and Recommendations for Future Action.

Bureau of Health Education (DHHS, CDC), Atlanta, Ga. Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 16 p., March 1978.

A national survey conducted in 1974-75 of health education in the Cooperative Extension Service resulted in a policy statement that was approved in March 1978 by the Extension Committee on Organization and Policy (ECOP), which is the national policy-making body of all State extension services. The survey assessed the direction of health education planning, national developments supporting health education efforts, underlying resources for increased emphasis on health education, implications of changes for educational programs, definition of health education, the role of extension in health education, health education and extension's four program areas, and interagency cooperation. The ECOP recommended that (1) a Federal position be created to give leadership to health education programming; (2) linkages be developed between the Department of Health and Human Services and voluntary, public, and professional health agencies, and between the Extension Services and such organizations as well as medical colleges and colleges with health education programs; (3) one director should preside in each State; (4) health education be established as a separate program area within the administrative structure of the Science and Education Administration and of the State Extension Services; and (5) each State should develop multidisciplinary team efforts and programs for professional improvement of staff. Numerous references.

*005

Health Education Units in State and Territorial Health Agencies.

Bureau of Health Education (DHHS, CDC), Atlanta, Ga. Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 36 p., April 1979.

Regional representatives to a Bureau of Health Education meeting in Atlanta in July 1978 formulated a questionnaire that was sent to State health departments to assess the health education units of the departments. Forty-eight States, American Somoa, and the Virgin Islands responded. Data are tabulated on administrative policies and procedures, organizational structure, personnel roles, professional staff, nonprofessional staff, budgets, relationships between health education activities and other activities carried out by the agencies, cooperation with other agencies, consultation services, and educational degrees held by staff. A copy of the questionnaire and a list of State and territorial departments are appended.

006

Health Education-Risk Reduction Grant Program, FY 1980.

Bureau of Health Education (DHHS, CDC), Atlanta, Ga. Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 287 p., (1980).

Projects funded under the $15.9 million Health Education-Risk Reduction (HERR) grant program, administered by the Bureau of Health Education, are described. These State and territorial projects are capacity-building grants to establish a focus within each program to update and maintain an inventory of existing health education-risk reduction programs and services, establish and foster working relationships among agencies, determine risk factor prevalence data, survey and establish systems for acquiring chronic disease morbidity and mortality data, and help communities develop organized approaches to risk reduction. Fifty-four State and territorial projects, 21 local intervention projects initiated in 1979, and 144 newly initiated local intervention projects were funded. Each program description includes the name of the applicant, a description of the target group, program objectives, methodology, and evaluation plans. Also included are (1) a map showing the geographic areas covered by the programs; (2) a chart showing the target group, target risks, setting, methodology, and funding level for each program; and (3) the reprinted Federal Register pages detailing rules and regulations that govern the HERR program.

*007

Health Education Assessment Survey: The Florida Panhandle, December 1978.

Ford, W. S. and Ford, A. S.

Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 155 p., August 1979.

The Florida Panhandle Health Education Resource Center (HERC), with partial funding by the Bureau of Health Education, contracted with the Institute for Social Research at Florida University to conduct a model, population-based household survey in the Panhandle Health Systems Agency and a survey of the area's primary care physicians. The household survey was designed to determine the health knowledge, attitudes, practices, and health status of the Panhandle population; the physician survey was designed to assess the extent and type of education provided by the physicians and to discern their receptiveness to working with HERC. Volunteer interviewers gathered data in the household survey, which employed a multistage area probability sample. In the physician survey, pretested questionnaires were mailed to all practicing primary care physicians in the area. The questionnaires were accompanied by endorsement letters from the Capital City Medical Society; the mailing was followed by a second mailing to nonrespondents and a subsequent mailing of a postcard reminder. Completed questionnaires were returned from 103 of the 230 targeted physicians. Major findings of the two surveys indicated that (1) 50 percent of the physicians believed that the average patient had inadequate health

knowledge; (2) household respondents had a generally uneven grasp of important disease indicators; (3) most household respondents were able to identify a source of health care in the community; (4) 57 percent of the physicians believed that patients were not interested in health education; (5) physicians did not realize the high value assigned to personal health by the population; (6) only 32 percent of the physicians were considering greater participation in health education activities; and (7) 39 percent of the physicians were willing to cooperate actively with HERC.

*008
New Organizational Avenues for Health Education: A Guide for Development of a Health Education Resource Center.
Imershein, A. W. and Davis, J. W.
Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 194 p., June 1979.

An analytical commentary on health education resource center development is offered, which provides a practical guide for new center development. Topics include (1) an examination of the conceptualization, early activities, and projected future directions of a pilot project for Florida; (2) brief reviews of the structure and activities of six health education resource centers in the United States; (3) the role, current activities, and future plans of health systems agencies in Florida; and (4) rules and guidelines for center development, focusing on organizational structure, bylaws, governing boards, staff, supplies, and budget. Several appendices include model drafts for elements cited in the above guidelines, the Senate Bill 552, a sample indexing system, a list of issues to be considered (when developing a resource center), and sample personnel policies.

*009
Community Partnership Organizations: A Better Way to Gain Participation in Health Programs.
MacNair, R.
Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 33 p., November 1980.

Guidelines for forming, organizing, and delivering community partnership organization (CPO) services are provided to those interested in developing citizen support of and participation in local public health agencies. Four basic and practical models are available for structuring CPO's; three can be used in health education and prevention programs. Other topics include choosing a facilitator, choosing and training personnel, convening a steering committee, selecting representatives, planning the structure, organizing leadership, helping citizen groups organize, organizing disadvantaged citizens, maintaining participation, working with citizens via specific techniques, organizing the interagency council, organizing the CPO council, and understanding the roles of citizen groups and agencies.

010
The Community and Its Involvement in the Study Planning Action Process.
Nix, H. L.
Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 205 p., 1977.
Available from: GPO; Stock No. 017-023-00120-5.

A theoretical base is offered for understanding the nature of community leadership and change, and practical guidelines are offered for identification of community leaders and influential groups as well as ways to involve community members in a community development or improvement process. Practical guidelines focus on how to implement planned change in a democratic, educational, nonpartisan setting. More specifically, these guidelines attempt to (1) describe a way to identify community leaders, groups, and factions; (2) discuss ways of organizing for health planning and general community development; and (3) delineate the steps and guidelines in a process for involving leaders, citizens, organizations, and factions in a study-planning-action process. It seems that two basic conditions underlie community disorganization: (1) increasing complexity of community organization and (2) increasing rates of social and other types of change. The survival of democratic communities in the United States depends upon more adjustive organization and decision-making processes. 12 references.

*011
Guidelines for a Community Health Education Program in a Correctional Setting.
Stelling, F. H. and Trisdale, D. J.
Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 25 p., (197-).

Guidelines for a community health education program in a correctional setting are provided for correctional and health education professionals. The guidelines were developed from the experiences of two health education projects that were organized and implemented by the Tennessee Department of Public Health. In planning a program, promoters should develop a clear statement of the program's purpose, involve community leaders, in-

volve personnel of the State Department of Corrections and the institution, and involve the institution's residents. Analyzing problems to be addressed by the program requires compiling statistical data, examining descriptive and subjective information, and involving the community in decisions concerning program priorities. The four phases involved in development of the actual program are selecting problems to be addressed, identifying objectives, selecting and developing subobjectives, and selecting resources and activities. Program implementation centers on staff training and organization of activities. Process, effectiveness, and efficiency evaluation should be part of the design throughout. Lists of resources outside the institution, lists of sources of data for community analysis, and a selected bibliography are appended.

*012

Health Awareness Projects, 1975-78.

Student National Medical Association, Inc., Washington, D.C.

Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 15 pamphlets, September 1980.

Overviews are provided of 22 Health Awareness Projects designed by chapters of the Student National Medical Association (SNMA) at 14 U.S. universities in 1975-78. The projects involved minority medical students, primarily black students, with health problems of the black community. The "self-control" projects promoted health awareness, health education, and health advocacy. Institutions at which projects were developed by SNMA chapters included the Medical University of South Carolina, Tufts University Medical School, Howard University College of Medicine, Duke University Medical School, Meharry Medical College, Yale Medical School, the University of California Medical College at Davis, Tulane University Medical College, Wayne State University, Emory University Medical School, the University of Kentucky, New York University, the Medical and Dental College of New Jersey, and the University of Iowa. Through the projects, participants were to (1) learn management skills in planning a health education program as well as skills in preparing proposals for health education programs; (2) interact with community agencies and medical school officials; (3) establish themselves as valuable resources for planning and implementing community-based disease prevention programs; (4) reinforce their commitments to establish medical practices associated with indigent communities; and (5) be effective role models.

*013

The Health Education Center, Pittsburgh, Pennsylvania.

Sullivan, D. A.

Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 27 p., 1979.

The Health Education Center is a project of the Health and Welfare PLANNING Association (HWPA), a United Way agency in Pittsburgh, Pennsylvania. The Center, which serves a 10-county area with a population of 3 million, provides information, technical assistance, and direct education to consumers, public and private health and educational organizations, and business and industry. Formation of the Center began with a recommendation in 1971 by the HWPA Health Task Force for stronger community-wide health education, a regional hearing on health education needs and resources called by the chairperson of the President's Committee on Health Education in 1972, a community meeting in 1973 to examine the recommendations of the hearing, and publication of guidelines by the HWPA and the Comprehensive Health Planning Association in 1974. Roundtable discussions by representatives of public and private institutions, a health education conference, and submission of a proposal for a 3-year grant of $180,000 in 1975 preceded the opening of the Center in 1976. The Center's major functions are program development, provision of information and communication services, and evaluation of and research on health education programs in the region. In addition to approximately 30 volunteers, the staff includes 8-11 professionals representing competencies in administration, communication, community organization, evaluation, health education, nursing, and planning.

*014

A Catalog of Free Loan or Low Cost Audio Visual Aids for Health Education.

Tuskegee Area Health Education Center, Inc., Tuskegee, Ala.

Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 24 p., (197-).

Annotated citations of inexpensive or free audiovisual aids for health education are provided. The sources cited cover aging, alcohol use and abuse, arthritis, blood pressure and hypertension, cancer, child growth and development, community health, courtship and marriage, dental health, diabetes, environmental health, epilepsy, family planning, eye and ear health, heart health, hospitals and nursing homes, the human body, kidney disease, mental retardation, narcotics, nutrition, obstetrics and gynecology, Pap smears, diseases affecting the rectum and colon, rehabilitation, sickle cell anemia, smoking, tuberculosis, and venereal diseases. A list of sources is appended.

015
A National Smoking Education Program Administered Through Local and State Health Departments.
Witte, J. J.
(Paper presented at the 10th International Conference on Health Education, London, England, September 1979), 6 p., 1979.
Available from: Health Education Council, 78 New Oxford St., London WCIA IAH, England.

The smoking education grant program of the Bureau of Health Education is discussed. Funds budgeted for the program were $3.5 million in 1979 and $4.5 million in 1980 for health education activities that emphasize smoking prevention. The Bureau disseminates funds to official health agencies that in turn become the focal points for health education programs emphasizing personal choice behaviors that reduce the risk of developing specific diseases. To be eligible for funding, applicants must devise and conduct health education programs emphasizing personal choice behaviors by persons at special risk, conduct public and professional education and information activities relative to lifestyle and chronic disease programs, serve as exemplary organizations in establishing effective risk reduction programs for health department staff, establish working relations with voluntary and professional organizations and educational groups, initiate planning for identification and documentation of information on the precursors of chronic diseases, develop a surveillance system for reporting incidence of smoking-related diseases, conduct prevalence and attitudinal surveys, and inventory health education and risk reduction activities on a statewide basis.

PATIENT EDUCATION

016
Current Resources in Patient Education.
Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 3 p., July 1980.

Citations of 51 recently published resources in patient education are provided. Most are available from the Community Program Development Division of the Bureau of Health Education, the American Hospital Association, or the American Society of Hospital Pharmacists.

*017
Discharge Planning: Reviewing the Issues.
American Hospital Association, Chicago, Ill.
Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 6 p., (1977).

Discharge planning encompasses all planned events that focus on the alleviation of patients' problems that might prevent their regaining a normal and productive role following initial health care. The process usually incorporates the efforts of patients' families and a multidisciplinary team of health care workers. In an effort to ensure continuity of comprehensive care, discharge planning involves attention to the rehabilitative aspects of care, provision of personnel to provide the care, and coordination of services. Patients most acutely in need of discharge planning include amputees, older patients with chronic diseases, diabetics, cancer patients, patients with emphysema or stroke, young patients with complicated conditions, postpartum patients, patients with inadequate home environments, patients under complicated medication regimens, and quadra- and paraplegics. Accreditation and review agencies and Federal and State laws are beginning to establish discharge planning standards. Such standards are most likely to be met when responsibility for coordination and patient education is fixed; followup evaluation techniques are specified; and medical, nursing, and administrative staffs are committed to the process. Any discharge planning program should provide for initiation of new staff, interdisciplinary planning, exposure of staff to different departments or settings, and inclusion of family members. 16 references.

*018
Hospital Inpatient Education; Survey Findings and Analyses, 1975.
American Hospital Association, Chicago, Ill.
Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 78 p., 1977.

Results of a national study of inpatient education are reported. The study was conducted in 1975 by the American Hospital Association, with partial funding from the Bureau of Health Education. Questionnaires were mailed to 5,770 community (non-Federal, short-term, general) hospitals in the United States; almost 80 percent responded. Telephone interviews were made to clarify data when necessary, and group discussions with hospital health educators were conducted. Results indicated that (1) 13 percent of the hospitals had a patient education policy; (2) 17 percent used a committee to generate and monitor patient education policy; (3) 46 percent placed responsibility for coordination of patient education activities in a

department, usually the nursing department; (4) 85 percent who cited a department reported a person within the department who was responsible for coordinating educational activities; (5) 33 percent used outside consultants for patient education activities; (6) 62 percent considered both the patient and the family as the target population for patient education programs; and (7) 68 percent had some provision to document patients' educational experiences. These findings resulted in recommendations for overall hospital programs and specific programs.

*019
Hospital Inpatient Education: Survey Findings and Analyses, 1978.
American Hospital Association, Chicago, Ill.
Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 88 p., 1980.

Findings are presented from the second of two surveys conducted by the American Hospital Association in cooperation with the Bureau of Health Education to assess the state of hospital inpatient education in 4,678 hospitals. Responses to survey questions, written comments on the survey, and followup phone conversations have confirmed that an increasing number of community hospitals have management structures that develop planned, coordinated patient education activities. In 1978 the number of hospitals that reported coordinated patient education programs was 2,009, as compared with 1,218 in 1975, when the first survey was conducted. The approaches most commonly selected by hospitals were nursing inservice education (1,107), nursing administration (452), or an education department (448). The most common adult patient education programs were in diabetes, heart disease, cancer, pregnancy, and surgery. For pediatric populations, the most common areas were diabetes, nutrition, hospital orientation, and postoperative care. Specific national and hospital-level recommendations concerning patient education programs are given.

*020
Implementing Patient Education in the Hospital.
American Hospital Association, Chicago, Ill.
Chicago, Ill., the Association, 293 p., 1979.
Available from: American Hospital Association, 840 North Lake Shore Drive, Chicago, IL 60611; AHA Catalog No. 1488.

Guidelines for implementing patient education are provided for hospital staff coordinators. The guidelines were developed by the American Hospital Association in cooperation with the Bureau of Health Education. Topics include the coordinator's role; means of gaining cooperation and support; committees; assessment and plan of action; policies, procedures, and job descriptions; means of financing patient education; and methods of designing a patient education program for specific patient populations. Case studies of successful coordinators and a bibliography are appended.

*021
Media Handbook: A Guide to Selecting, Producing, and Using Media for Patient Education Programs.
American Hospital Association, Chicago, Ill.
Chicago, Ill., the Association, 126 p., 1978.
Available from: American Hospital Association, 840 North Lake Shore Drive, Chicago, IL 60611; AHA Catalog No. 1258.

Guidelines for utilizing media for patient education programs are provided for use by hospital staff. The guidelines were developed by an assistant professor at the University of Illinois College of Nursing and by the American Hospital Association in cooperation with the Bureau of Health Education. Topics include needs assessment; formulation of learning objectives; development of content outlines; selection of learning activities; selection production, and use of instructional media; and program evaluation. 45 references.

*022
Primary Nursing: Can It Improve Patient Education?
American Hospital Association, Chicago, Ill.
Atlanta, Ga., Centers for Disease Control, 8 p., 1977.

Primary nursing is examined as a practice mode and as an organizational innovation that can foster patient education within inpatient units. Originating at the University of Minnesota Hospital in 1969, primary nursing is basically a return to the case method of assignment, with each nurse carrying a case load of four to eight patients. The nurse is responsible, over a 24-hour period, for collection of the nursing assessment data and preparation and maintenance of the plans for nursing care delivery and evaluation. The literature on primary nursing suggests that it increases nurse-physician and nurse-nurse communication and improves nurse-patient communication, as compared to team-teaching methods. Primary nursing also enhances comprehensiveness and continuity of services and ensures that nurses do more nursing than administrative work. The head nurse, when relieved of unit management responsibilities, helps the primary nurse meet both organizational and individual nurse-patient educational goals by providing the primary nurse with a clinical role

model and resource person. Studies have found that primary nursing, as compared to team teaching, is less costly and less conducive to turnover among nursing personnel. 17 references.

*023
The Problem-Oriented Medical Record: Implications and Potential for Improving Patient Education.
American Hospital Association, Chicago, Ill.
Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 11 p., (1977, reprinted 198-).

A review of the literature concerning the problem-oriented medical record (POMR) identifies sources that indicate the advantages of the POMR in improving patient education efforts. The POMR approach is a means by which the patient's records are restructured from the traditional source-oriented format to a format in which information is organized around the patient's problems. Components of a particular POMR include a defined data base, a complete problem list, plans for caring for the patient, and progress notes. Of 150 resources discussing POMR in the "Hospital Literature Index" between 1970 and 1975, only 2 discussed use of the POMR to improve patient education. Patient activities cited include making entries into the record and reviewing discharge summaries. The structure and organization of the POMR force recognition of the educational components of diagnostic and therapeutic efforts, emphasize patient education as a significant aspect of patient care responsibility, ensure careful documentation of educational efforts, enhance communication by focusing attention on patient problems and the common progress-recording form, emphasize integration of the description of a technical procedure into the context of the patient problem, improve decision making by focusing attention on priority problems, reduce diversity and variability of an undesirable nature among health team members, and improve health team integration. 26 references.

024
Some Commercial Suppliers of Patient Education Materials.
American Hospital Association, Chicago, Ill.
Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 2 p., 1980.

The names, addresses, and telephone numbers are provided of 21 firms and organizations that supply materials useful for patient education programs.

025
Some Sources for Patient Education Videotape Programs.
American Hospital Association, Chicago, Ill.
Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 2 p., 1980.

Names, addresses, and telephone numbers are provided of 17 firms and organizations that offer patient education videotape programs.

*026
Staff Manual for Teaching Patients About Chronic Obstructive Pulmonary Diseases.
American Hospital Association, Chicago, Ill.
Chicago, Ill, the Association, 406 p., 1979.
Available from: American Hospital Association, 840 North Lake Shore Drive, Chicago, IL 60611; AHA Catalog No. 1317.

Guidelines for teaching patients about chronic obstructive pulmonary diseases are provided for use by hospital staff. The guidelines were developed by the Center for Health Promotion of the American Hospital Association in cooperation with the American Lung Association and numerous other organizations and individuals. Funding was provided by the Bureau of Health Education. Topics include the disease process, psychological issues, community resources, pulmonary diagnostic studies, physical therapies, nutrition, medication, home use of respiratory equipment, teaching-learning processes, and means of organizing for patient care.

027
Medication Teaching Manual: A Guide for Patient Counseling.
American Society of Hospital Pharmacists, Washington, D.C.
2nd ed. Washington, D.C., the Society, 312 p., 1980.

A manual of medication counseling monographs is designed for hospital staff who decide what information should be included in the medication teaching portion of the hospital's patient education activities. The monographs are listed in alphabetical order, and information is presented in a question-answer format. The drug's purpose, how and when it should be used, special instructions, proper storage conditions, side-effects, and special precautions are discussed. Appendices include an American Hospital Association statement on health education citing the role and responsibility of health care institutions, American Society of Hospital Pharmacists' guidelines on pharmacist-conducted patient counseling, medication administration diagrams, and a pocket medication profile.

*028

Shared Leadership--A New Approach to Patient Care.
Bernheimer, E.
Atlanta, Ga., Centers for Disease Control, 16 p., (1978).

A 3.5-year experimental program utilizing a team approach to patient education for diabetics was implemented at a 500-bed community teaching hospital. During a 6-month planning period, a medical advisory committee stipulated the topics to be covered, and an allied health advisory committee developed program content. The team included a nurse, dietitian, pharmacist, social worker, pastoral care counselor, and patient education coordinator. The education process for each patient involved prescription of education by the physician, assessment of the patient by each team member, formulation of a teaching plan during a team conference, implementation of the plan by team members, assessment of teaching during a second conference, and followup after discharge. Though the lack of contact between team members, except during conferences, hampered the team somewhat, the tight structure of the team, the leadership of the referring physician, and carefully kept records mitigated this problem. Team members exhibited an increased sensitivity to patient problems and an understanding of the problems brought about by patients who give conflicting information to different team members. As compared to other diabetics, team-taught patients had a better understanding of the uses of commercially produced insulin, received more information on exercise and other problems related to diabetes, and were provided with better followup services. 20 references.

*029

The Team Approach to Patient Education: One Hospital's Experience in Diabetes.
Bernheimer, E. and Clever, L. H.
Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 46 p., 1977.

A team approach to patient education for diabetics was implemented during a 3.5-year experimental period at St. Mary's Hospital in San Francisco, California. Funded by a $30,000 grant from the California Regional Medical Program, the team included five dietitians, two clinical pharmacists, two social workers, and all members of the nursing department. Six sessions on interviewing were attended by every nurse, and a subsequent orientation program replaced this formal procedure. An educational curriculum was outlined, with sections assigned according to disciplinary expertise. The patient teaching process involved prescription of patient education by the physician, assessment of each patient by each team member, formulation of a teaching plan during a team conference, implementation of the plan by team members, assessment of teaching during a second conference, and followup after discharge. Computerized hospital data were collected on diabetic patients served by the hospital during a 12-month period prior to the initiation of the program. Similar data on the 112 patients served by the team and data from hospital staff were collected. The data indicated that (1) the individualized plans were amenable to nearly all patients; (2) staff members were able to allay the typical fears of the patients; (3) 98 percent of the patients remembered the special treatment they had received after 3 months; and (4) 88 percent of the referring physicians found the teaching to be consistent with their approach. Lists of program materials and copies of evaluation instruments are appended. 39 references.

*030

Practical Considerations in Evaluating Patient-Consumer Health Education Programs. Paper Presented at the National Conference on Hospital-Based Patient Education, August 9-10, 1976, Chicago, Illinois.
Bryant, N. H.
Atlanta, Ga., Centers for Disease Control, 6 p., (1977).

The Office of Consumer Health Education of the College of Medicine and Dentistry of New Jersey has evaluated numerous health education programs. Among them are a venereal disease hotline, diabetes classes, and the Smoke-No-More program at the Monmouth Medical Center; patient teaching efforts at the diabetes clinic at Morristown Memorial Hospital; the Health Carnival sponsored by the St. Francis Medical Center in Trenton; an experimental summer health education program for thirty-five 12-year-olds; the patient-teaching program at Shore Memorial Hospital; a preoperative teaching program at Our Lady of Lourdes Hospital in Camden; and a home visitation program by the Visiting Nurse Association of Perth Amboy General Hospital of Middlesex County. These program evaluations indicated that (1) health education program objectives are rarely measurable; (2) evaluation procedures and budgetary requirements must be carefully planned prior to evaluation; (3) a specific person should be designated to evaluate data; (4) long-term followup is the most problematic area associated with evaluation; (5) sample sizes must be large enough to allow for statistical significance; (6) location of adequate control groups has proven to be difficult; and (7) the reasons for evaluation should be explained to staff to relieve pressures associated with such assessments.

*031
Staff Manual for Teaching Patients About Hypertension.
Chewning, B.
Chicago, Ill., American Hospital Association, 326 p., 1978.
Available from: American Hospital Association, 840 North Lake Shore Drive, Chicago, IL 60611; AHA Catalog No. 1319

Guidelines for teaching patients about hypertension are provided for use by hospital staff. The guidelines were developed by the Center for Health Promotion of the American Hospital Association in cooperation with numerous organizations and agencies. Funding was provided by the Bureau of Health Education. Topics include the disease process, psychological issues, medication, nutrition, relaxation, teaching-learning processes, and means of organizing for patient education. Appendices include a glossary, bibliographical materials for use by staff and patients, and lists of resources for patients.

*032
Overview of Evaluation. Paper Presented at the National Conference on Hospital-Based Patient Education, August 9-10, 1976, Chicago, Illinois.
Deeds, S. G.
Atlanta, Ga., Centers for Disease Control, 4 p., (1977).

Programs with objective, quantifiable evaluation designs are likely to gain the support and cooperation of health educators and other personnel involved with health education programs in the hospital. Objective evaluation standards can be historical, normative, theoretical, absolute, or negotiable. In planning an evaluation, it is important to designate specific users of the data to be generated so that the evaluator can determine whether internal or external validity is sought. Of the essential elements of a research design, namely, inclusion of pre- and posttests, inclusion of a control group, random assignment of subjects to control or experimental situations, and assurance of a representative sample, the one essential to any evaluation is inclusion of the posttest. Evaluators should remember that different media and messages will appeal to different audiences; that group methods provide peer reinforcement; and that a careful educational diagnosis of predisposing, enabling, and reinforcing factors enhances program success. Before designing an evaluation, the evaluator should review the pertinent literature and research local resources. 4 references.

*033
Staff Manual for Teaching Patients About Diabetes Mellitus.
Espenshade, J. E.
Chicago, Ill., American Hospital Association, 385 p., 1979.
Available from: American Hospital Association, 840 North Lake Shore Drive, Chicago, IL 60611; AHA Catalog No. 1318.

Guidelines for teaching patients about diabetes mellitus are provided for use by hospital staff. The guidelines were developed by the Center for Health Promotion of the American Hospital Association in cooperation with numerous organizations and individuals. Funding was provided by the Bureau of Health Education. Topics include psychological issues, dietary management, exercise, urine testing, insulin, insulin-induced hypoglycemia, oral hypoglycemia medications, sick days and their management, care of the feet, teaching-learning processes, and means of organizing for patient education. Bibliographical citations of materials designed for use by staff and patients are appended.

*034
Patient Education in the Outpatient Department. Paper Presented at the National Conference on Hospital-Based Patient Education, August 9-10, 1976, Chicago, Illinois.
Fylling, C. P.
Atlanta, Ga., Centers for Disease Control, 4 p., (1977).

Hospital-based outpatient programs should be designed to incorporate patient education components into their health delivery systems. This development would coincide with the trend among hospitals, reported by the American Hospital Association, toward more ambulatory treatment as opposed to inpatient care. When considering implementation of outpatient education services, the hospital should consider characteristics of its staff and patients, amount of time available for contact between staff members and patients, space available for patient education, and audiovisual equipment available. The in- and outpatient programs should be integrated into a comprehensive system, and clearly defined curricula should be designed for each setting.

*035
A Health Education Demonstration Project in a Pediatrics Ambulatory Care Setting. Paper Presented at the National Conference on Hospital-Based Patient Education, August 9-10, 1976, Chicago, Illinois.
Goodfriend, S.
Atlanta, Ga., Centers for Disease Control, 10 p., (1977).

Beginning in 1974, the Institute of Public Affairs undertook a 3-year health education demonstration project in the Pediatrics Department of the Roosevelt Hospital in New York City to (1) establish a community hospital model and (2) evaluate the outcomes of the educational intervention by experimental and survey methodologies and by cost-benefit and cost-effectiveness analyses. The project involved (1) formation of a multidisciplinary health education committee to identify problems within the department, and (2) facilitation by the health education coordinator of group process within the committee to resolve the problems. To remedy one of the identified problems--the inappropriate utilization of the children and youth clinic--the committee used the clinic's computer service and data base to monitor selected patients on a monthly basis, used a program planning chart to list the effect of inappropriate utilization of health providers by patients, and implemented a controlled cost-effectiveness analysis to evaluate different educational methodologies. The analysis indicated that health education interventions increased the number of appointments kept by patients. Statistical tabulations are appended. 11 references.

*036

Measures of Diabetic Patient Knowledge, Attitudes, and Behavior Regarding Self-Care.

Marquis, K. H., et al.

Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 4 v. 330 p. (Report No. R-2380-HEW), August 1979.

"Measures of Diabetic Patient Knowledge, Attitudes, and Behavior Regarding Self-Care" reports on research undertaken to identify or develop reliable, valid measures of diabetic patient self-care in the areas of management tasks, patient knowledge of drug self-administration, and patient attitudes about compliance. Self-care topics include safety, medication, nutrition, urine testing, access to medical care, and hygiene. A review of the literature identified studies which attempted to measure related concepts and found information on nutrient intake, pill taking, and visits to doctors. Questionnaires were developed and administered to 500 diabetic patients sampled from 4 treatment facilities. Supplementary information was obtained through retest questionnaires, interviews with people who knew the patients, and patient skill demonstrations. Of the 26 short scales designed to measure behavior, 3 exhibited the full range of desirable characteristics; 12 appeared to have some remediable problem; and 11 either manifested measurement problems or could not be evaluated adequately. The validity of the 21 short scales for measuring knowledge could not be determined. Though findings are limited since attitude measures were not retested, analysis revealed that answers were determined by the object of the attitude, the wording of the items, and the favorability of the attitude indicated by the choice. Results indicate that patient compliance is selective and that the level of compliance with one part of the regimen is unrelated to compliance with other prescribed activities. Hence, the theory must be broadened to account for variation, and longer questionnaires should be developed to measure all meaningful variation. Variables judged important in compliance, an evaluation of published measures of variables, and new measures developed during this study are appended. Numerous references.

*037

Keynote Speeches; Presented at the National Conference on Hospital-Based Patient Education, August 9-10, 1976, Chicago, Illinois.

Merwin, D. J. and Ogden, H. G.

(Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education), 15 p., (1978).

The objectives and accomplishments of the National Center for Health Education and the Bureau of Health Education are discussed. The National Center develops national strategies for health education, performs an advocacy function for health education, attempts to improve the state of the art of health education through research and demonstration projects, and provides consultation and technical assistance to health education practitioners. The National Center focuses particular attention on health education in the workplace, federal legislation, and patient education. Major efforts in these areas include coordination of resources, resolution of conflict among providers, compilation of resource materials, and assemblage of expert technical assistance. The Bureau, established in September 1974, attempts to identify sound programs and successful models in the private and public sectors and to enhance lateral communication among the health care professions. The National Health Information Act of 1976 (Public Law 94-317) aids the efforts of the Bureau by providing authority for research and evaluation in the field, encouraging demonstration projects, and stressing the need for public information dissemination.

*038

Financing Patient and Family Education at the Hospital Level. Paper Presented at the National Conference on Hospital-Based Patient Education, August 9-10, 1976, Chicago, Illinois.

Pritchett, S.

Atlanta, Ga., Centers for Disease Control, 8 p., (1977).

To finance patient, family, and community health education at the hospital level, the health educator must identify available funding sources, understand hospital budgeting, and examine current trends in these areas of health education. Inclusion of health education as a separate item on each patient's bill should be avoided since this practice typically results in refusal of reimbursement by third-party payers and neglect of the educational needs of many patients because limited numbers of staff are designated as educators. Incorporation of health education costs into the day rate allows all patients to share costs equally, an equitable situation considering that 80 to 90 percent of a typical patient population will have the same educational needs. Often, hospitals charge for patient teaching materials in much the same way that they charge for other central supply materials. The utilization of full-time education coordinators for patient and community education is increasing, and multidisciplinary teams are being utilized in both inpatient and outpatient classroom settings. Private donations and contracts with other agencies can help finance community health education programs such as health fairs and extensive outreach efforts; auxiliaries can provide volunteer assistance; and universities can supply planning and evaluation assistance.

*039

Using a Nutrition Clinic's Waiting Room for Patient Education. Paper Presented at the National Conference on Hospital-Based Patient Education, August 9-10, 1976, Chicago, Illinois.

Scanlan, J. M.

Atlanta, Ga., Centers for Disease Control, 2 p., (1977).

The Outpatient Department Nutrition Clinic at the University of Virginia Hospital has instituted a program to provide patient education in the clinic's waiting room. The clinic serves an indigent population with the help of staff members and various groups of volunteers, and shows educational films, teaches patients craft skills, invites guest speakers to the clinic, presents cooking demonstrations, operates a Swap Shop for used clothes and household goods, displays easy-to-make household items, initiates poster campaigns throughout the hospital on nutrition issues, and provides free handouts of materials produced by various commercial companies.

*040

Patient Education Workshop: Summary Report.

Simmons, J.

Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 105 p., 1976.

The Center for Disease Control was the site for a patient education workshop on January 26-27, 1976. Participants noted that, in all cases, patient education programs began due to several catalysts: new demands for patient discharge planning, available funds from regional medical programs or other Federal sources, professional contact with an educator, a literature review, and the requirement in the medical-nursing audit portion of the Joint Commission on Accreditation of Hospitals' review criteria. Patterns of service ranged from assumption of total responsibility by the clinical nurse to designation by a multidisciplinary team of a specific health care provider as health educator. Though materials from outside sources are often used at the outset of a program, educational staff usually develop their own materials as the program progresses. Almost all programs employ multidisciplinary teams. Methods of referral differ according to the size of the hospitals. Ongoing monitoring of program efficacy is necessary, but controlled experiments in practice settings are avoided by most institutions. Skills associated with effective education include skills pertaining to planning, facilitating, interviewing, developing forms, and budgeting. Workshop participants made recommendations about reimbursement, consultation services, preparation of health workers, and necessary guidelines and instruments. An overview of patient education, a list of patient education materials, and examples of patient education materials are appended.

*041

Pharmacist-Provided Medication Information for the Ambulatory Patient. Paper Presented at the National Conference on Hospital-Based Patient Education, August 9-10, 1976, Chicago, Illinois.

Solomon, D. K.

Atlanta, Ga., Centers for Disease Control, 12 p., (1977).

Drug information provided to the ambulatory patient by the pharmacist can involve patients more actively in drug therapy and increase compliance rates. As the health professional in the best position to detect noncompliance to drug regimens, the pharmacist should consult with patients to review instructions for proper home use of medications. Appalachian Regional Hospitals (ARH), a health care system of 10 hospitals and related facilities, uses pharmacists to provide patient education services related to drug regimens. Pharmacists provide direct verbal as well as written information. A 2-year study concerning research on patient education and pharmacist involvement within the ARH system utilized a stratified randomized sample population and a controlled posttest design. After 6 months, during which pharmacists consulted with patients in an experimental group, home visitations and

interviews were initiated for both experimental and control patients. Interview data indicated that patients who consulted the pharmacist exhibited higher compliance rates, made fewer errors in the rate of medication utilization, and demonstrated greater knowledge about their drugs. All subjects and physicians involved in the study had favorable attitudes toward the consulting pharmacists and felt that the pharmacists should be paid for consultations. Study instruments are appended. 9 references.

042

Patient Education System for a Rural Primary Care Center: Lowndes County, Alabama.

Sullivan, M. E.

Paper presented at the 10th International Conference on Health Education, London, England, September 1979. 10 p., 1979.

Available from: Health Education Council, 78 New Oxford St., London WCIA 1AH, England.

A systems approach for integrating health education into a total health care delivery system was developed by the Health Education Center of Tuskegee, Alabama, for use in the poor, rural area of Lowndes County. The system uses patient education protocols in individual or small group educational settings, patient education diagnosis forms, and documentation records. The protocols were developed from interviews with local clinic staff, review of clinic files to ascertain the most frequently encountered health problems, and review of the 1970 census report for the county to assess mortality rates and hospital discharge diagnoses. Protocols were developed for the 10 most prevalent health problems. Each patient referred for education is given an informal pretest, from which an educational diagnosis is made. Then, the patient is referred for administration of one or more educational protocols. Each protocol can be individually taught or team taught. Posttests are given after each educational intervention, and all patient teaching is documented via an appointment log, a patient log, a disease index, a patient index, and individual patient folders.

*043

How Hospitals Evaluate Patient Education Programs. Paper Presented at the National Conference on Hospital-Based Patient Education, August 9-10, 1976, Chicago, Illinois.

Ulrich, M.

Atlanta, Ga., Centers for Disease Control, 9 p., (1977).

United Hospitals of St. Paul, Minnesota, has directed evaluative efforts in patient education toward the development of an ongoing evaluation system. The Program Effectiveness Project developed by the Human Resources Planning Council of St. Paul, of which United Hospitals is a member, has developed an evaluation system that measures outcomes for all clients, applies measures from outside the facility, reports on results at regular intervals, and assesses acceptability of performances. The system provides for a statement of purpose or mission by each program, an outline of program goals, a statement of program objectives, a statement of measures to indicate how achievement of objectives will be determined, a delineation of performance expectancies to indicate the degree to which each objective is achieved, an assignment of relative importance to objectives, a description of clients served, and regular reports of performance data. The system has been used to clarify program goals and directions, ensure cost-effectiveness in programming, and provide clear and concise data on service effectiveness.

*044

Staff Manual for Teaching Patients About Rheumatoid Arthritis.

Wallace, R.; Heiss, M. L.; and Bautch, J. C.

Chicago, Ill., American Hospital Association, 458 p., 1979.

Available from: American Hospital Association, 840 North Lake Shore Drive, Chicago, IL 60611; AHA Catalog No. 1320.

Guidelines for teaching patients about rheumatoid arthritis are provided for use by hospital staff. The guidelines were developed by the Center for Health Promotion of the American Hospital Association in cooperation with numerous other organizations and individuals. Funding was provided by the Bureau of Health Education. Topics include the disease process; psychological issues; medication; rest, energy conservation, and joint protection; heat and cold therapy; therapeutic exercises; unproved methods of treatment; nutrition management; community resources; teaching-learning processes; and means of organizing for patient education. Appendices include patient education guidelines, a model for planning patient education, a bibliography for health care professionals, and lists of readings and audiovisuals suggested for use with patients.

SCHOOL HEALTH EDUCATION

045

The Primary Grades Health Curriculum Project.

Bureau of Health Education (DHHS, CDC), Atlanta, Ga. Centers for Disease Control, Center for

Health Promotion and Education, (DHEW Publication No. (CDC) 80-8382), 30 p., 1980.

An overview is provided of the Primary Grades Health Curriculum Project (PGHCP) which was developed as a companion project to the School Health Curriculum Project. The PGHCP seeks to provide high quality experiences about health for boys and girls in the primary grades (K-3) of school. Topics include the subject matter of the curriculum; the classroom method of doing and learning; training for teachers and administrators; beginning, spreading, and maintaining the project, and evaluation of the benefits of the project.

046
The School Health Curriculum Project.
Bureau of Health Education (DHHS, CDC), Atlanta, Ga.
Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education (HHS Publication No. (CDC)80-8359), 52 p., December 1977, reprinted July 1980.

An overview is provided of the School Health Curriculum Project (SHCP), written through the cooperative efforts of the Bureau of Health Education and the National Heart, Lung, and Blood Institute of the National Institutes of Health. Topics include the relationship between health behavior and health education; SHCP systems and education; appreciation and understanding of the body as the subject matter of SHCP; structure and function of SHCP; teacher-training programs associated with SHCP; initiation, maintenance, and extension of SHCP; and evaluation of the benefits of SHCP.

047
Bureau of Health Education School Health Curriculum Project. Listing of Evaluative Endeavors.
Bureau of Health Education (DHHS, CDC), Atlanta, Ga. Community Program Development Div.
Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 3 p., October 1977.

The titles and authors of 18 evaluative studies of the School Health Curriculum Project (SHCP) are listed.

*048
Health Education: Awareness and Action. A Project of the California State PTA.
California Congress of Parents and Teachers, Los Angeles.
Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 12 p., (1978).

The Health Education Awareness and Action Campaign was designed by the California Congress of Parents and Teachers to secure the active support of parent teacher association (PTA) members, school board members, and representatives of community groups for implementing comprehensive health education programs in State elementary and high schools. The program was funded in fall 1975 by the National Congress of Parents and Teachers, through funds from the Bureau of Health Education. The project, which was designed to reach local boards of education, developed a multimedia program and trained 2 PTA members from each of the 32 PTA districts in 1976, and trained 181 members from PTA districts, councils, and out-of-council units in 1977. Trained personnel made over 100 presentations to boards of education. In March 1977, the California Board of Education approved a framework designed to help school districts develop planned, sequential comprehensive health instruction programs in grades K-12. The program is designed to cover current and emerging health problems and to develop critical thinking and individual responsibility for health.

*049
School Health in America: A Survey of State School Health Programs.
Castile, A. S. and Jerrick, S. J.
2nd ed. Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 220 p., August 1979.

The American School Health Association initiated a survey to determine the status of State-level school health programs in 1978. Results from two sets of surveys, completed between April 1974 and the end of 1978, offer the first major review of school health programs in the United States in 10 years. All 50 States eventually responded; 22 States reported mandatory school nursing certification requirements; 9 States reported permissive requirements; 3 States reported they were developing certification requirements; and 13 States reported that no plans were underway to develop certification requirements. Only 32 States certify teachers of health in health education with 10 of these States offering dual certification in health and physical education. Four States and the District of Columbia offer only dual certification in health and physical education. Louisiana offers certification in health and safety education. The remaining 13 States have either no requirements or general teacher certification requirements for school health educators. Concerning school health education programs, 5 States require comprehensive curricula; 13 States have general laws requiring health education but no specific provisions; and 5 States have either no requirements or have no program. Instruction in venereal disease is required in 9 States.

Many States require instruction in specific health content areas such as safety, nutrition, mental health, and consumer health. Standards for environmental quality of schools exist in 32 States, usually enforced by the State Department of Health. Standards ranged from minimal requirements for toilet facilities to specifically outlined standards for all phases of the school environment.

*050
For the Health of It.
Colorado Congress of Parents, Teachers, and Students, Denver.
Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 1 folded sheet (5 p.), (1979).

The Colorado Parent-Teacher Association and Parent, Teacher, and Student Association advocated the passage of the Colorado Health and Survival Education Act of 1975 and, as a result of the passage of that legislation, developed two rural and two urban workshops to help formulate a comprehensive school health education scheme. The workshop teams consisted of parent representatives, teachers, students, administrators, nurses, social workers, advisors, and community leaders. During the first 2 years of operation, the teams identified health concerns in local communities, identified pertinent community agencies and individuals, developed a process or activity concerning health education for the schools, and educated workshop participants about the importance of comprehensive health education. Two project schools were selected for evaluation of experimental curricula. The workshops concluded that an effective health education program should have accountable leadership, a broad scope, a sequential structure, identifiable objectives, current and scientifically accurate instructional materials, community support, and a carefully designed teacher-training program.

051
Health Education for Youth in Primary Schools.
Davis, R.
Paper presented at the 10th International Conference on Health Education, London, England, September 1979. 9 p., 1979.
Available from: Health Education Council, 78 New Oxford St., London WCIA IAH, England.

The School Health Curriculum Project (SHCP) and the Primary Grades Health Curriculum Project (PGHCP) are comprehensive health education models carried out under the auspices of the Bureau of Health Education. The SHCP is used by 235 school districts in 33 States, and the PGHCP by 134 school districts in 24 States. The models are designed for students 10-12 and 5-9 years old, respectively. The curricula seek to minimize reliance on information dissemination, moralistic approaches, and reading skills; instead, they maximize hands-on experiences, activity, peer teaching, multimedia presentations, real life situations, and multidisciplinary professional teaching and community resource teams. The SHCP is administered in part by the National Center for Health Education, a private, nonprofit organization that will also test and disseminate other model curricula and generally stimulate the private sector to produce more materials in school health education. The Bureau is also involved in a contract with the National Congress of Parents and Teachers to develop citizen advocacy resources for the curricula models, in a program to develop curricula for junior and senior high school students, and in an effort to evaluate the SHCP.

052
Teenage Health Teaching Modules. Project Description.
Education Development Center, Newton, Mass.
Atlanta, Ga., Centers for Disease Control, 4 p., November 30, 1979.

The Teenage Health Teaching Modules project, funded by the Bureau of Health Education, is an adolescent health education program conducted by the Education Development Center (EDC). (EDC is a publicly supported, nonprofit organization that has been engaged in educational research and development for over 20 years.) Working closely with the U.S. Office of Education, the project will develop and distribute educational materials and activities for teenagers and promote cooperation and coordination among key people, organizations, and project staff at all levels. Current and new materials will be integrated into modules that will be field tested across the country before nationwide dissemination. The project's advisory group includes 16 persons whose work relates to adolescent development, education, and health and well-being in society.

*053
Comprehensive Health Education Management Model.
Florida State Dept. of Education, Tallahassee.
Atlanta, Ga., U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control, Center for Health Promotion and Education, 81 p., September 1980.

The Florida Comprehensive Health Education Management Model promotes a multifaceted approach to uniting State health and State education resources to improve comprehensive school health education in grades K-12. It has resulted from a 10-year joint effort headed by the Florida Department of Education and a contract with the Bureau of Health Education. The model can help health education managers in other States (1) utilize their official, professional, and voluntary health and educational resources to improve health education, and (2) promote health education as an integral component of a State's health and education plans. In Florida, health education categorical funding is allocated according to student population and designated specifically for salaries of district health coordinators, inservice training, curriculum design, testing of innovative health education concepts through pilot projects, development or acquisition of instructional materials, technical assistance, and monitoring and evaluation. This funding allocation encourages local school districts to replace fragmented health teaching with sequentially planned comprehensive health instruction throughout a student's education. The model is based on five major management functions that must operate at the State, regional, district, school, and classroom level, namely, advocacy, clearinghouse, coordination, evaluation, and innovation. Key aspects of the program are a permanent advisory and technical assistance structure at the State, regional, and local levels; instructional programs developed by local school districts; and collaboration with community agencies and resources.

*054

Comprehensive Health Education in New Mexico Public Schools; A Community Action "Manual," 1978-1980.

Grace, H.

Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 33 p., September 1980.

The Comprehensive Health Education (CHEd) program in New Mexico provides a comprehensive, sequential health education curriculum for public school students and coordinates health instruction with health services. The priority targets for CHEd programming are heart disease, accidents, and dental and periodontal disease. The State Board of Education has included CHEd programming in its Minimum Educational Standards. Still, local support is needed to ensure the introduction of CHEd programming in all 88 school districts in the State. At a minimum, CHEd programming should be used for nutrition; human growth; family health; health maintenance; consumer health; environmental health; community health; and mental, emotional, and social health. The Community Health Council represents an effective means of organizing CHEd integration into school districts. The Council should inform itself concerning CHEd, determine the extent of health education programs in local schools, conduct a needs assessment, develop a Council statement on CHEd, approach school boards formally to request that CHEd be implemented in district schools, and work with school personnel to formulate an implementation plan. State legislation and synopses of pilot projects are appended. 3 references.

055

Comparison of Successful Sex Education Programs and Evaluation Techniques.

Gunn, W. J.

(Paper presented at the 10th International Conference on Health Education, London, England, September 1979), 16 p., 1979.

Available from: Health Education Council, 78 New Oxford St., London WCIA IAH, England.

The results of a study designed to establish base-line data on the objectives, curriculum design, and evaluation methodology of sex education programs are reported. The study was conducted by Mathtech, Inc., for the Bureau of Health Education. Findings indicate that (1) most sex educators agree on the objectives of sex education, although some may encourage particular value systems; (2) in most elementary schools, sex education is informal and unplanned; (3) many students receive instruction in the biological aspects of reproduction and menstruation in grades 5-6; (4) programs in junior high school tend to emphasize biological aspects, and few discuss the changes and feelings that accompany adolescence; (5) high school teachers devote more time to sex education than do their counterparts in lower grades; and (6) the type, duration, content, sexual makeup of the classes, and classroom atmospheres of high school programs are widely diverse. The most important innovations in sex education identified by the survey involve peer counseling, specific programs for parents, and programs that provide contraceptives. The review of sex education studies indicates that the public generally supports sex education programs.

*056

Keynote Address to the National PTA Conference on Health Education, "From Challenge to Action," Chicago, Illinois, January 25, 1978.

Lashof, J. C.

Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 14 p., 1978.

The National Congress of Parents and Teachers has worked to make comprehensive health education an integral part of efforts to improve community health. Numerous studies, particularly the long-term study of death rates carried out by the Human Population Laboratory of the California Department of Public Health, demonstrated the direct relationship between certain personal health practices and physical health status. The Center for Disease Control has responded to this situation by forming a comprehensive base of health knowledge to help raise health awareness within schools, media, public service organizations, and other institutions; the Center also has been instrumental in forming a comprehensive, sequential curriculum for children in grades K-12. If this curriculum is to be implemented at the local level, the Center and the Bureau of Health Education will need the help of parent-teacher associations at all levels.

057
School Health Education Project.
National Center for Health Education, San Bruno, Calif.
San Bruno, Calif., the Center, 1 folded sheet (5 p.), (197-).

The School Health Education Project (SHEP) was designed by the National Center for Health Education to coordinate the efforts of school health educators as well as other individuals, organizations, and agencies to promote health curricula. Supported financially by the Bureau of Health Education as a direct result of the Bureau's work with the School Health Curriculum Project (SHCP), the Primary Grades Health Curriculum Project (PGHCP), and other school health education projects, SHEP promotes school health education leadership and advocacy, promotes information exchange, and provides technical assistance. Specific activities of SHEP include developing a national action strategy, developing a school health education advocacy and promotional campaign, sponsoring work groups for the SHCP, providing recommendations concerning the evaluation of the SHCP and other curriculum models, developing information and communication systems for those involved in school health education, developing technical assistance and training systems, and establishing continuing working relationships with national organizations involved in developing school health education.

*058
Address to the National PTA Conference, "From Challenge to Action," Chicago, Illinois, January 26, 1978.
Relic, P. D.
Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 17 p., 1978.

Parent-teacher associations at all levels must work to introduce comprehensive health education programs into all school districts. Twenty-two States do not mandate comprehensive school health education, and the other 28 States do little more than provide guidelines, leaving actual implementation to individual school districts. If Federal, State, and local governments are to intervene to ensure the inservice training and curriculum development activities necessary to implement sequential comprehensive programming, parental and community involvement are necessary. Psychological, dental, and medical care efforts should be integrated into vocational and educational programs. A significant financial commitment from the Office of Education is needed if these goals are to be realized.

059
The Fight Against Smoking Starts in Kindergarten.
Schwartz, C. and Trenk, B. S.
American Lung Association Bulletin 64(7):9-13, September 1978.

The North Bellmore School District in Long Island, New York, employs the Primary Grades Health Curriculum Project (PGHCP) to help students develop a positive self-image, to reduce risk-taking behavior, and to increase their desire to maintain a healthy body. Developed by the American Lung Association and the Seattle school system, with funding from the Bureau of Health Education, the PGHCP involves daily 30-minute sessions for 10-12 weeks at the district's six elementary schools. The hands-on, self-discovery approach employs a combination of materials, tested lesson plans, and intensive teacher training. The program includes both large-group lectures and small-group exercises that require the use of cassettes, filmstrips, books, games, models, puzzles, records, and do-it-yourself craft projects. Evaluations of the program have demonstrated that it develops students' health and social skills as well as health knowledge and behavior. The program has operated in the original Seattle development site, in four regional test sites (including the North Bellmore district), and in several other school districts. Every participating school commits itself to spreading the PGHCP to other schools, health professionals, and community groups in the district.

OTHER

060
Current Awareness in Health Education.
Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, October 1978- (Monthly).

Descriptions of health education programs and citations and abstracts of current journal articles, monographs, conference proceedings, reports, and nonpublished documents in health education, which have been entered into the Center for Health Promotion and Education's national health education data base, are provided for use by health educators and others. Only documents published or programs initiated since 1977 are referenced. Topic areas include community health education; health education in occupational settings; health education methodology; patient education; professional education and training; regulation, legislation, and administration; research and evaluation; risk reduction; school health education; self-care; and sex education. Author, subject, and program title indexes are appended.

061

Directory of the Coalition of National Health Education Organizations.

Atlanta, Ga., Centers for Disease Control, 17 p., July 1980.

Names and addresses of key personnel affiliated with, and brief descriptions of, member organizations of the Coalition of National Health Education Organizations are provided. The descriptions cover year of establishment, a statement of purpose, membership, publications, and frequency of meetings. Member organizations include the Health Education Section of the American College Health Association; the Public Health Education Section of the American Public Health Association; the School Health Education and Services Section of the American Public Health Association; the American School Health Association; the Association for the Advancement of Health Education, American Alliance for Health, Physical Education, Recreation and Dance; the Conference of State and Territorial Directors of Public Health Education; the Society for Public Health Education; and the Society of State Directors of Health, Physical Education, and Recreation.

062

Focal Points.

Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, August 1975- (Monthly).

"Focal Points" is a monthly report initiated by the Bureau of Health Education, primarily directed to health education providers. It presents current information on health education issues and programs at the local, State, and Federal levels.

063

HEIRS (Health Education Information Retrieval System). Thesaurus of Health Education Terminology, 1976.

Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 209 p., 1976.
Available from: NTIS; Order No. HRP-0014366.

"HEIRS," a thesaurus of health education terms, was originally developed by the Health Communications Branch of the Public Health Service, then updated by staff in the Division of Health Education at the Johns Hopkins School of Hygiene and Public Health. Where applicable, accession numbers of health education documents within the HEIRS system accompany each descriptor. (Many of these documents originally appeared in "Health Education Monographs.")

064

The Center for Disease Control Employee Directed Lifestyle Health Education Program.

Althafer, C.
Paper presented at the 10th International Conference on Health Education, London, England, September 1979, 11 p., 1979.
Available from: Health Education Council, 78 New Oxford St., London WCIA IAH, England.

The Employee Directed Lifestyle Education Program of the Center for Disease Control (CDC) is designed to encourage employees to lead healthier lives. The program was planned and implemented by CDC employees with the help of SHARE (Service to Help All Regular Employees), the CDC employee organization. SHARE provided employee leadership in the form of a steering committee to determine policy, set direction, and provide overall coordination of the several program committees. Employee program committees were formed to address smoking cessation, weight loss and nutrition, physical fitness, and stress reduction. Other committees are formed as necessary. SHARE also has developed a community resource guide, recruited community and national agencies to develop onsite programs, developed several community and onsite programs, and conducted state-of-the-art seminars for employees. The primary instrument for initiating the program with employees is the

Canadian government's version of the health risk appraisal, which provides computer data on employee health status. Each participant receives counseling in a group setting concerning the health risks identified by the appraisal. Records are kept on general success rates of each program, and cumulative data are being kept on health hazard appraisal results.

*065
Legislation Regulating Smoking Areas: A Selective, Annotated Bibliography, June 1976.
Axel-Lute, P.
Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, National Clearinghouse for Smoking and Health, 23 p., December 1976.

Annotated citations are provided of (1) legislation passed into law through June 1976 regulating smoking areas, and (2) literature related to such legislation. The citations include State laws and regulations, Federal regulations, judicial ordinances, cases, bills before Congress, Federal documents, law review articles, periodicals, and other sources.

*066
Financing for Health Education Services in the United States.
Blue Cross and Blue Shield Associations.
Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 63 p., October 1980.

Information concerning health care financing in the United States, with particular emphasis on third-party payment and other financing arrangements for health education, is offered for providers and payers. Topics include health care expenditures, sources of funds, the impact of third-party payment, the health education delivery system, third-party payment for health education services, health maintenance organizations, consumer payment for health education services, providers of health education services, means of financing health education services, and types of health education services that should be offered. Numerous references.

*067
Information Regarding the Bureau of Health Education's Work in the Area of Sex Education to Reduce Unwanted Teenage Pregnancies.
Bureau of Health Education (DHHS, CDC), Atlanta, Ga.
Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 8 p, (1980?).

The Bureau of Health Education has conducted several efforts as part of national health efforts to reduce the increase in teenage pregnancies, which have reached 1.3 million per year, and to ameliorate other sex-related problems in the country. In 1977, a group of individuals representing health, education, youth, clergy, and other groups met with staff members of the Bureau and recommended that Federal activity be directed toward collection of data on current sex education activities, encouragement of leadership training, development and support of experimental community programs, and assessment of educational materials. Subsequently, the Bureau contracted to gather information regarding the effectiveness of ongoing sex education programs and the development of improved evaluation methodology. Data from the final report of the contract has led to the development of 10 different sex education programs by school and nonschool agencies, several models of sex education programs for parents that operate effectively in different environments and with different subpopulations, and a 22-month study on the perceived and real barriers to sex education. All programs are being completed under contract.

*068
Self Care.
Bureau of Health Education (DHHS, CDC), Atlanta, Ga.
Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 1 sheet, (1977).

Self-care conferences held in 1975-77, newsletters, resource persons, programs, books and articles, and key words to be used in searching data bases and libraries are listed.

*069
State Legislation on Smoking and Health, 1979.
Bureau of Health Education (DHHS, CDC), Atlanta, Ga.
Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education (HHS Publication No. (CDC)80-8386), 89 p., June 1980.

The legislative record of each State legislature during 1979 concerning smoking and health is outlined. All State legislatures except Kentucky convened in 1979, and only Nevada did not introduce legislation pertaining to smoking and tobacco products. As of December 31, 1979, 346 bills had been introduced pertaining to smoking and tobacco products, and 39 bills had been passed into law by 25 States. The laws addressed limitations on smoking, tobacco commerce, smoking and schools, advertising by the tobacco industry, sales to or use by minors, insurance, and other topics.

*070
State Legislation on Smoking and Health, 1980.
Center for Health Promotion and Education (DHHS, CDC), Atlanta, Ga.
Atlanta, Ga., the Center, (1981?).

Data on smoking and health legislation introduced or passed by the States during 1980 is presented. Of the 44 State legislatures that convened in 1980, 11 did not introduce legislation concerning smoking and health, and 1 introduced resolutions rather than laws, leaving 32 States which introduced 192 bills. Of these bills, 26 were passed into law by 17 States. A State-by-State listing of legislation by category and a summary of laws introduced and enacted in 1975-1980 is included.

*071
An Overview of the Rockland County Network of Self-Help Groups: A Case Study Presentation.
Claflin, B. and Thaler, P. K.
Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 8 p., (1978).

One of the activities of the Department of Consultation and Education of the Community Mental Health Center of Rockland County, New York, is to maximize utilization of community support groups, particularly self-help groups. A 1975-76 survey of the county indicated that it contained over 40 self-help groups. Though the department has made an effort to bring the groups together for periodic coordination meetings, the groups' normal routines and support systems leave them little additional energy to expend on external coordination. Obstacles to group activities include scarce funding for small groups and lack of referrals from the professional community. The Rockland County Widow and Widowers Group, which was an outgrowth of a more encompassing group for newly single persons, meets weekly at the mental health center. As the group increased its membership from 13 to 40, it developed some formal structure, and the professional facilitator was able to curtail involvement. The group provides social services and invites expert speakers to address issues of importance to widowed persons. The group has also created subgroups to help newly widowed persons and elderly widowed persons.

*072
Keynote Address; Presented at the National PTA Conference, Atlanta, Georgia, February 6, 1980.
Foege, W. H.
Atlanta, Ga., Centers for Disease Control, 13 p., 1980.

Events indicate that a national strategy is developing in the United States in the area of disease prevention. In 1978 in Atlanta, a group of health professionals from around the country examined different areas of health, assessed the state of the art, and outlined objectives for the nation for 1990. These objectives are complemented by those developed by the World Health Organization's "Health for All by the Year 2000" program. In the past year; Model Standards for Community Preventive Health Services have been developed by State, county, and city health officers; the American Public Health Association; and the staff of the Center for Disease Control (CDC). Three national groups have met in recent years to set national priorities in the field of preventive medicine. Organizationally, the recent national immunization program provides a prototype for future efforts involving nationwide systems of government and volunteer groups.

*073
The Self-Help Group as a Vehicle for Helping Individuals Cope With Physical Health Problems.
Gartner, A.
Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 9 p., (1978).

As infectious diseases give way to chronic disorders as the leading killers of Americans, health programs have begun to deemphasize medical intervention and emphasize self-help efforts. The consumer-centered health maintenance model, which provides users with skills central to effective response to chronic conditions, has been adopted by numerous self-help groups. Specific groups have been formed to deal with addiction, blood conditions, bronchopulmonary conditions, endocrine conditions, health maintenance, special education needs of youth, infant mortality, mental illness, neuromuscular disorders, obesity, physical disabilities, sensory disorders, skin disorders, and surgery rehabilitation. The functions of the five major types of self-help organizations include rehabilitation, mutual aid, primary care, prevention and case finding, and advocacy and professional and public education. The self-help movement is effectively responding to trends in consumerism, budget cuts, feminism, civil rights, patient activation, and demystification of medicine. Attention in the future will be directed toward the movement's relation to reimbursement practices, national health insurance policies, patterns of care, operations of health maintenance organizations, health education, and professional medical education. 11 references.

*074
Self-Help Groups as a Vehicle for Helping Individuals Cope With Emotional Problems.
Gartner, A.
Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 18 p., (1978).

Alcoholics Anonymous (AA), Parents Anonymous (PA), Synanon, Recovery, "living with" groups, and some life transition groups are compared. The most important common feature of these mental health self-help groups is that the role of the person who has already lived through the experience is critical to programming. Groups designed to help members break a noxious habit differ from those designed for persons undergoing a role transition, such as the recently divorced or widowed. The latter type of groups, which include Parents Without Partners (PWP), La Leche League, and various widow groups, emphasize the formation of a new community in which members undergoing similar role transitions can immerse themselves. A crucial area in which types of groups differ is related to their association with professionals. AA and other similar groups are totally lay-oriented, neither organized nor led by professionals. On the other hand, groups of ex-patients, "living with" groups, and life transition groups involve professionals to varying degrees. 52 references.

*075
Commentary on Legal, Clinical, Economic, and Ethical Issues Related to the Self-Help and Mutual Aid System.
Gartner, A.; Pepper, B.; and Stander, R. J.
Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 11 p., (1978).

The emergence of networks of self-help and mutual aid groups has given rise to numerous legal, clinical, economic, and ethical issues. When viewing the self-help movement in its entirety, differences appear in relation to the specificity of the various groups' scopes, the tightness or looseness of structure, the formality of leadership, the involvement of professionals, the extent to which groups deal with external problems, and the relative role of individual and group responsibility. In dealing with social deviants, such as the severely mentally ill or alcoholics, self-help groups should realize that (1) the social nature of such groups may be the most difficult aspect to which its members must adapt; (2) some deviants tend to immerse themselves wholly within the group, treating it as their universe; (3) social distance between the professional facilitator and the group must decrease if the relationship is to be beneficial; and (4) the self-help group can decrease tensions between ethnic groups. The chief benefits of self-help groups are associated with their tendency to personalize and decompartmentalize life; to promote self-responsibility, particularly in personal health care; and to encourage consumerism. In the future, self-help groups should clarify differences distinguishing self-help from professional help and lobby for third-party payment for self-help services.

*076
Public Attitudes Toward the Swine Flu Immunization Program.
Gunn, W. J.
Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 765 p., January 1981.

Beginning in August 1976, the Opinion Research Corporation conducted 9 monthly national opinion surveys (with approximately 1,500 adults in each survey) to determine (1) awareness of the swine flu problem and the Swine Flu Immunization Program, (2) the level of potential demand for the vaccine, (3) sources of information about the shot, (4) knowledge of where to obtain a shot, (5) reasons for indecision or procrastination, and (6) perceived barriers to immunization. Results indicated that public awareness was high in August 1976 and rose steadily thereafter; vaccine acceptance rose through October, then fell significantly after news reports of possibly hazardous side effects; vaccine rejection rose slowly through October, then jumped after the reports of side effects; reported vaccinations rose from 1 percent in October to 32 percent in December, when they leveled off; in December, 27 percent reported a reaction to the vaccine, but by February only half as many reported a reaction; by December, 82 percent who wanted the vaccine knew where to get it; and the most often reported reason for rejecting the vaccine was fear of adverse effects, followed by a lack of belief in the necessity of the shot, lack of belief in its effectiveness, and advice from a physician not to receive the shot. Changes to the program suggested by the data began to be incorporated in October 1976. Monthly reports were sent to State health departments, the Office of Management and Budget, and the White House Domestic Council. Because the questionnaire was developed around the Health Belief Model, the data may contribute to a greater understanding of public immunization behavior, particularly differences among target groups. The results of each monthly survey are detailed.

*077
Racial Differences in Attitudes Regarding Childhood Immunization. Paper Presented at the New Mexico Health Education Coalition Meeting, September 20-22, 1978, Albuquerque, New Mexico.
Gunn, W. J.

Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 24 p., 1978.

During September 1977 and February 1978, the Bureau of Health Education contracted with Opinion Research Corporation to conduct nationwide telephone surveys regarding the public's attitudes toward childhood immunization. More than 2,000 interviews were completed with parents and other adults in each of the 2 survey waves. During the February wave, six 60-county national probability samples were canvassed. The results of the February wave indicated that (1) white families reported significantly higher rates of infection for rubella than did other races, but significantly lower rates for measles; (2) white children were more likely to be immunized against diphtheria, pertussis, tetanus, polio, measles, rubella, mumps, and polio; (3) blacks indicated significantly greater acceptance of all vaccines than whites; (4) whites and blacks differed significantly in their reasons for not accepting various vaccines; (5) blacks were significantly less trusting in general in the safety of vaccines than were whites; (6) whites were less likely to trust the safety of specific vaccines; (7) blacks were more skeptical than whites about the probable efficacy of large public immunization programs; (8) blacks were more likely than whites to believe in the imminence of epidemics and individual infections; and (9) whites were less likely to indicate that they planned immunizations for their children during the next 12 months.

*078

The Use of a National Opinion Poll to Track a Major Health Problem.

Gunn, W. J.

Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 20 p., (1977).

A series of nine monthly national opinion surveys was initiated in August 1976 by Opinion Research Corporation under contract with the Center for Disease Control to track public attitudes regarding swine flu immunization. Telephone interviews were conducted of randomly designated households in a minimum of 100 different locations throughout the country during each survey. Approximately 1,500 interviews were conducted in each of the 9 waves.

*079

Self Help Among Youth.

Kohler, M. C.

Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 3 p., (1978).

During the last 10 years, the National Commission on Resources for Youth has promoted the formation of self-help groups among young people. Examples of programs developed, implemented, administered, and staffed by persons 9 to 18 years old include a computerized car-pooling project in Denver, Colorado; an environmental awareness campaign in Coos Bay, Oregon; and tutoring projects in Newark, New Jersey and Philadelphia, Pennsylvania. The programs have given the youth a sense of self-esteem and social responsibility, while providing needed services for local communities.

*080

Self Care.

Levin, L. S.

Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 18 p., (1978).

The Bureau of Health Education convened a seminar on November 3-4, 1976, to delineate self-care concepts, issues, and strategies that could be instructive to interested laypersons, legislators, educational and health practitioners, and Federal and private funding sources. In the discussion of self-care education efforts in Oregon, Maine, and Washington, D.C., and of a proposed program in New Haven, Connecticut, participants agreed that (1) the general goal of self-care education is to increase an individual's capacity to self-manage; (2) self-care encourages a shift in locus of control from the professional to the layperson; (3) self-care seeks to illuminate social causes of health risk and social means of eliminating risk; (4) the content of self-care should reflect the preferences of clients and be offered in the context of their lifestyles; (5) passivity must be eliminated and client involvement highlighted in self-care education; and (6) evaluation methods currently used in self-care are primitive. These considerations, and an overview of self-help groups in general and school groups in particular, led seminar participants to recommend efforts to resolve professional prejudice against self-care, certify persons with self-help skills, encourage funding for self-care efforts by third-party payers, provide professional technical support to self-care efforts, build demonstration models, and provide informational liaisons for various self-care programs. 13 references.

081

Selected Federal Health Information Clearinghouses and Information Centers.

National Health Information Clearinghouse, Washington, D.C.

Atlanta, Ga., Centers for Disease Control, 7 p., September 22, 1980.

Names, addresses, and telephone numbers of selected Federal health information clearinghouses and information centers are provided.

082
Common Ground in Health Education.
Ogden, H. G.
Eta Sigma Gamman 12(3):3-6, Fall-Winter 1980.

Health educators must find a common working ground if they are to continue to receive funding and public support. Developments over the decade indicate the rise of government sponsorship for health education: the formation of the President's Committee on Health Education in 1971; delivery of the Committee's Report to the White House in 1973; establishment of the Bureau of Health Education (BHE) in 1974; inclusion of health education among the 10 priorities of the national health planning system in 1975; enactment of Public Law 94-317 in 1976; passage of the Health Services Amendments in 1978; publication of the Surgeon General's 1979 Report outlining a national program of health promotion; and initiation of a health education grant program at BHE in 1979. In response to this support, health educators must formulate evaluation designs that measure how cost-effectively health education programming ameliorates leading health problems. The initial success of the BHE grant program suggests that health educators are capable of finding the common ground necessary for this effort. Other indicators of the discipline's competence include the process of role delineation for health educators now underway under the auspices of the National Center for Health Education, the immense growth of contracts and collaborative efforts involving the Department of Education and the Public Health Service, the growth of the Coalition of Health Education Organizations, and the development of a joint health and education approach to evaluation of school health curricula.

083
Health Education as an Element of US Policy.
Ogden, H. G.
International Journal of Health Education (Geneva) 23(3):150-155, 1980.

The U.S. government's role in setting and implementing health policy is outlined. The Surgeon General's report on health promotion and disease prevention, entitled "Healthy People" (1979), focused on lifestyles, health protection, and health services. Specific objectives for the coming decade are defined in 15 major subareas, with health education a critical element in nearly all of them. Along with public disenchantment with the medicalization of health, other factors have contributed to health education's new visibility, including the consumer, environmental, and women's rights movements, as well as a general popular movement toward better health through lifestyle changes. A number of major proposals are being advanced through the budgetary system for implementation of health education and promotion programs, some directed toward specific disease problems and health behaviors, others toward the capability of State and local agencies to carry out effective health education and risk reduction programs. Responsibilities associated with the emergence of health education as a prominent element in national health policy are examined.

084
Health Education: A Federal Overview.
Ogden, H. G.
Reprinted from Public Health Reports, Vol. 91, No. 3, p. 199-205, May-June 1976.

Health education activities in the Federal government, particularly within the Department of Health, Education, and Welfare, are reviewed. In response to the President's 1971 Health Message to Congress, the President's Committee on Health Education recommended the establishment of a National Center for Health Education based in the private sector. The Committee also recommended that an agency (subsequently, the Bureau of Health Education) be created within the Center for Disease Control to serve as an operating focus for health education within the Department. The report also led to the establishment of an Intradepartmental Health Education Committee (with staff support from the Bureau of Health Education) to assure effective coordination of Federal resources devoted to health education purposes. 8 references.

085
Issues and Challenges in Health Education.
Ogden, H. G.
Paper presented at the Annual Convention, American School Health Association (51st, Atlanta, Georgia, October 14, 1977), 11 p., October 14, 1977.
Available from: ERIC; Order No. ED-148 789

In a presentation at the American School Health Association meeting in Atlanta, Georgia, on October 14, 1977, the director of the Bureau of Health Education, Center for Disease Control, discussed the government policy shift in medicine from treatment to prevention, the need to develop a definition of reasonable expectations upon which to base health education efforts, and general interests at the

national level. The movement toward prevention can be seen in such recent legislation as the Health Planning and Resource Development Act of 1975 (P.L. 93-641) and the Consumer Health Information and Health Promotion Act of 1976 (P.L. 94-317). Similar legislation is needed to directly affect school health education. Examining issues of reasonable expectations covers such topics as the development of maximum feasible goals that can be realized over specific time periods, assumptions about available resources, and questions of cost benefit and cost effectiveness. General interests that are receiving priority attention include immunization of children, a campaign against smoking, and reduction in unwanted pregnancies, particularly among adolescents. Finally, health education policies must be viewed as transcending local issues, so that a reasonable national direction can be mapped.

*086

Public Attitudes Toward Immunization: August 1977 and February 1978.

Opinion Research Corp., Princeton, N. J.

Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 3 v., 2,311 p., September 1978.

Two national surveys, the first from August to September 1977 of 2,006 adults, the second from January to February 1978 of 2,080 adults, were conducted by the Opinion Research Corporation for the Center for Disease Control to (1) determine the relationship between past experience with immunization (particularly Swine Flu Vaccine) and present willingness to accept immunization, (2) establish base-line data about public attitudes concerning a range of issues related to immunization, and (3) develop a predictive model of intent to be immunized or to have children immunized. Findings indicated that (1) smallpox is perceived as very serious by half of all adults, and 75 percent of adults and 69 percent of children are immunized; (2) 66 percent consider polio very serious, and 71 percent of adults and almost all children are immunized; (3) half consider tetanus very serious, and 69 percent of adults and 68 percent of children are immunized; (4) half of all adults and 94 percent of children are immunized for diphtheria-tetanus-pertussis; (5) 41 percent of adults and 86 percent of children are immunized for measles; (6) half consider typhoid very serious, yet only 33 percent of adults and children are immunized; (7) 25 percent of adults and 75 percent of children are immunized for rubella; (8) 20 percent of adults and half of the children are immunized for mumps; and (9) few adults and children are immunized for influenza, and few adults consider influenza serious. Race was the most important discriminant variable in predicting intent to be immunized; whites were more likely than nonwhites to indicate they did not intend to be immunized during the next 12 months. Other important variables were perceived likelihood of local occurrence of the disease, perceived personal susceptibility, and perceived seriousness of the disease. Volume I contains interpretations of major findings, with summary tables; Volume II contains detailed tables of wave I results; and Volume III contains detailed tables of wave II results.

*087

A Study of the Impact of the 1978-79 National Influenza Immunization Program on Specific Physician Groups. Final Report.

Opinion Research Corp., Princeton, N. J.

Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 355 p., November 1979.

A nationwide survey of 239 general practitioners, 287 internists, 252 pediatricians, and 252 industrial physicians was conducted in 1979 by Opinion Research Corporation under contract with the Center for Disease Control to assess the views of these professionals about the 1978-79 public influenza immunization program. Telephone interviews were conducted from September 5 through October 12. Results of the survey indicated that (1) 90 percent of the physicians administered the flu vaccine; (2) 93 percent thought the vaccine was safe; (3) those who administered the vaccine were most likely to use it among patients with chronic illnesses and elderly patients; (4) 90 percent informed their patients of the risks and benefits associated with the vaccine; (5) fewer than 10 percent found it difficult to obtain the vaccine; (6) fewer than 25 percent were aware that Medicaid reimbursements were available to cover the costs of the vaccine; (7) only 30 percent thought that the average adult should be vaccinated; (8) only 10 percent thought that children should be vaccinated; (9) 47 percent reported dissatisfaction with the program, often due to lack of information or poor program management; and (10) 70 percent supported future programs.

*088

1979 Immunization Survey.

Opinion Research Corp., Princeton, N.J.

Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 2 v. 416 p., August 1979.

Findings of a study of immunization conducted among adults and children in the continental United States are presented. Areas covered included immunization and

vaccination histories of the public, related medical histories, intent to be immunized, and attitudes toward and knowledge about certain diseases. The U.S. sample was supplemented by statewide samples of the adult populations of Arkansas and California. Of those adults surveyed, 69 percent claimed to have been vaccinated against polio; 50 percent had had DTP shots; 25 percent had had rubella shots; and 17 percent had had mumps immunizations. Almost all children were reported to have had polio and DTP vaccines. Adults believe, to a great degree, in the protection rate of immunization for these diseases. Belief in high cure rates for flu, mumps, and measles is widespread among adults, but significantly fewer believe in the curability of polio, typhoid, rabies, and smallpox. Flu is considered the disease most likely to occur, followed by measles, mumps, and rubella. The 1979 Influenza Immunization Program reached only 33 percent of the targeted group of high-risk adults. Nevertheless, messages addressed to that population concerning their vulnerability to flu appear to be getting through. Most high-risk adults claim to have had the flu at some time in their lives. Adults recognize the vulnerability of a pregnant woman who has neither been immunized against rubella nor contracted the disease previously, and realize the threat of rubella to an unborn infant. Parents claimed to keep up-to-date immunization records on their children. Finally, data from California and Arkansas generally confirm these findings.

*089

Media Coverage of Events Relating to the Swine Flu Program.

Porte, M. and Weiler, E.

Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 524 p., January 1981.

Detailed analyses are offered of media coverage of the Swine Flu Immunization Program and related events. Most data were collected from January 1976 to February 1977. Coverage was rated as either "positive," "balanced," or "negative." Sources surveyed were 4 newspapers with the largest circulation in the 4 regions of the country, 39 regional newspapers, the nightly news programs on the 3 television networks (as well as the "Today" show), magazines, editorial cartoons, and religious newsletters and religious wire service stories.

*090

The Present State of Self Help.

Riessman, F.

Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 11 p., (1978).

As an increasing number of self-help groups emerge to fulfill needs once met by traditional institutions, it is becoming important to understand the nature of such groups, their relationship to professionals, and their potential. Self-help groups involve face-to-face interactions, usually among peers; originate spontaneously; emphasize personal participation and indigenous membership; begin from a position of powerlessness; supply participants with a reference group and a base line for activity; and stress the concrete, subjective, experiential, intuitive, and empathic. By maintaining the integrity of these characteristics, self-help groups can form excellent complements to professional groups, which generally emphasize the opposite traits. However, the former must be careful to prevent too close of an association with the latter, since professionally led agencies may seek to dominate and socialize self-help groups to existing professional norms. Self-help models based on assertiveness training, specific diseases, and methods in which professionals are limited to technical assistance roles are most effective in maintaining the integrity of the self-help group. Finally, while the self-help movement is typically viewed as a middle-class movement, social and political efforts by low-income groups demonstrate their ability to organize self-help coalitions. 1 reference.

*091

Health Care Marketing: An Annotated Bibliography.

Robinson, L. M. and Cooper, P. D.

Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 50 p., March 1980.

Citations and annotations are offered of 166 articles on health care marketing.

*092

Review and Evaluation of Smoking Control Methods: The United States and Canada, 1969-1977.

Schwartz, J. L. and Rider, G.

Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education (HEW Pub. No. (CDC)79-8369), 87 p., December 1978.

An evaluative review of smoking control methods used in the United States and Canada from 1969 to 1977 is presented. Smoking cessation methods reviewed include self-care techniques, techniques employing medications, nonprofit programs, commercial methods, hypnosis, medically sponsored programs, programs undergoing research and development, mass media and community programs, and miscellaneous techniques. Nonprofit programs reviewed during the period included school programs, the

5-day plan, in-residence treatment programs, American Cancer Society Quit Smoking Clinics, Lung and Tuberculosis Association clinics, programs of the American Health Foundation, the Kaiser Foundation Stop-Smoking Clinic, Toronto Clinic programs, and other group programs. Medically sponsored techniques include surveys of the attitudes of health professionals, physician counseling and clinics, and multiple risk factor preventive trials. Control and cessation designs currently undergoing research include aversive procedures and self-management techniques. A list of doctoral dissertations published in 1970-1976 on smoking cessation methods are appended. Numerous references.

*093

The Hazards of Cigarette Smoking During Pregnancy.

Witte, J. J.

Atlanta, Ga., Centers for Disease Control, Center for Health Promotion and Education, 7 p., (1978).

The effects of smoking by pregnant women on their offspring's birthweight and physical and intellectual development, and other problems associated with smoking during pregnancy, demonstrate the need for physicians and other health professionals who work with pregnant women to help them stop smoking. Such professionals should set examples by refraining from smoking in the presence of patients, display informative posters on smoking and pregnancy in waiting areas, distribute brochures and posters obtainable from the American Cancer Society and the American Lung Association, periodically encourage patients who have resolved to cease smoking, and refer smokers to cessation clinics. 10 references.

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